



Protecting, Maintaining and Improving the Health of All Minnesotans

July 6, 2023

Licensee
Legacy Care Home
5230 Circle Down
Golden Valley, MN 55416

RE: Project Number(s) SL28372016

Dear Licensee:

On June 16, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 29, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jonathan Hill', with a stylized flourish at the end.

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 19, 2023

Licensee

Legacy Care Home

5230 Circle Down

Golden Valley, MN 55416

RE: Project Number(s) SL28372016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the MDH imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = \$3,000

The total amount you are assessed is \$3,000. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jessica Schoeneker', with a stylized flourish at the end.

Jessica Schoeneker, Supervisor
State Evaluation Team
Email: jessica.Schoeneker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28372016-0 On March 27, 2023, through March 28, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) active residents receiving services under the Assisted Living with Dementia Care license. On March 29, 2023, the immediacy of correction order 1750 has been removed, however non-compliance remains at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 485		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 2 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 27, 2023, at 10:20 a.m., the surveyor observed the menu plan posted on the refrigerator in the facility kitchen was for one week running from Monday, March 27, 2023, through Sunday, April 2, 2023.	0 485		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 3 On March 27, 2023, at 10:20 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the menus are prepared and posted on the refrigerator in the kitchen weekly. When asked if the menus were distributed to the residents at least one week in advance RN/LALD-A stated they are not, but they would be happy to start that process. The licensee's Food Service and Menu Planning policy dated August 1, 2021, indicated menus will be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 4 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record included documentation of training and competency evaluation of the delegated task of medication administration for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B started work with the licensee on September 22, 2022. On March 28, 2023, at 7:30 a.m., the surveyor observed ULP-B administer medications to licensee's residents. On March 28, 2023, at 7:40 a.m., the surveyor and ULP-B observed the contents of the medication boxes for R1 and R2, where ULP-B was scheduled to pass medications.	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 5 ULP-B's employees record lacked documentation that ULP-B had been trained and deemed competent by a registered nurse (RN) before starting to pass medications to licensee's residents. On March 28, 2023, at 8:15 a.m., ULP-B stated for medication training, registered nurse/licensed assisted living director (RN/LALD)-A completed training and competency and hands on training when ULP-B started working for the licensee. In addition, ULP-B stated RN/LALD-A is available during their shift, and if they have questions, they ask RN/LALD-A. On March 28, 2023, at 9:00 a.m., RN/LALD-A stated the process for ULP medication training included one on one medication training taught by an RN, shadowing another medication passer, and ended with a competency skills review with the RN before providing medication administration to residents. RN/LALD-A was not sure why the paper competency was not completed on ULP-B. RN/LALD-A stated ULP-B was a certified nursing assistant (CNA) and wondered if the paper competencies were not included in the licensee's CNA new hire pack. RN/LALD-A, indicated the competency review paperwork should have been completed for ULP-B. The licensee's Medication & Treatment policy dated August 1, 2021, indicated ordered or prescribed medications and or treatment/therapy may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medication or perform the treatment or therapy, or by unlicensed personnel who have been delegated medication administration tasks	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 6 by a registered nurse at licensee. In addition, the policy indicated ULPs must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EP plan lacked the following content: - Establishment of the Emergency Program (EP); - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information; - Emergency Officials Contact Information;	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 8 - Primary/Alternate Means for Communication; - Methods for Sharing Information; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power; and - Integrated Health Systems. On March 28, 2023, at 1:35 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee's EP plan was missing required information. Additionally, RN/LALD-A stated the licensee will update the EP to reflect the requirement. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "it is the intent that [licensee] to have in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 9 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide audible smoke alarms in the resident rooms throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 10 On a facility tour on March 28, 2023, at approximately 2:00 p.m. with registered nurse/ licensed assisted living director (RN/LALD)-A it was observed that smoke alarms were installed throughout the facility, but several were not interconnected so activation of any one alarm activates all alarms throughout the facility. Smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout facility. It was also observed the smoke alarm located outside in the immediate vicinity of the basement sleeping room did not operate during a test. This deficient finding was visually verified by RN/LALD-A at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 28, 2023, at approximately 2:00 p.m. with registered nurse/ licensed assisted living director (RN/LALD)-A it was observed that a ceiling light fixture cover was missing, exposing the internal wiring of the light fixture. Light fixture devises are required to be maintained as designed and installed. It was also observed that the posted fire safety and evacuation floor plan indicated using the attached garage with no exterior exit door as an exit from the habitable areas of the facility. Marked exits are required to be maintained with exit doors that lead to the public way from the interior of the facility. It was observed the room stated by RN/LALD-A to be an activity room had a window that was missing the crank operator handle and was not able to be opened. Please identify this room as an activity room and not a sleeping room on the facility fire safety and evacuation floor plan. A multi plug current tap was observed with a multi plug power tap plugged into it in the northern	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 most resident room in the new addition portion of the house. Multi plug current taps and power taps are required to be used according to the manufactures listing and installation instructions. These deficient conditions were visually verified by RN/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on March 28, 2023, at approximately 1:30 p.m. of documents provided by registered nurse/ licensed assisted living director (RN/LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of available documentation indicated the fire safety and evacuation floor plan did not include an accurate layout, location, and numbers of resident rooms on the main floor and	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 14 basement of the facility. Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Procedures were available but not included in the plan. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by RN/LALD-A during the interview at approximately 1:45 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 15 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on March 28, 2023, at approximately 2:00 p.m. with registered nurse/ licensed assisted living director (RN/LALD)-A it was observed that a portable space heater was present in the resident room in the northeast corner of the main original house within this dementia care facility. Space heaters are not	0 820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 820	Continued From page 16 allowed in sleeping rooms of dementia care facilities. This deficient condition was visually verified by RN/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 970	Continued From page 17 The findings include: The licensee's Assisted Living Contract, included the following language indicating a waiver of liability in various sections: Page 17, section N "Hold Harmless": "You agree to hold harmless [licensee], its owners, management, all of their officers, trustees, staff, and personnel from any and all claims arising from an injury or illness incurred through natural or normal causes during his life at [licensee]." Page 17, section O "Liability" "The resident agrees to be liable and responsible for all obligations herein references, monetary and otherwise, of the resident and where this agreement has been executed by a party designated below." On March 27, 2023, at 12:15 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee was aware of the liability clauses in the contract were questionable from a sister site survey but thought the current wording could be "okay." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01620	Continued From page 18 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment monitoring no more than 14 days after initiation of services, and every 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 19 R1 started services with licensee September 20, 2022. R1's signed Daily Service Plan for AL Clients dated August 19, 2022, indicated R1 received the following services: medication administration, medication reminders, feeding, bathing assistance, hygiene and grooming assistance, dressing, grooming, toileting, laundry, mental health services, monitoring and assessments. R1's record included an admission/initial assessment dated August 20, 2022, which included the uniform assessment tool requirements. A 14-day reassessment dated October 4, 2023, only stating no changes and a 90-day assessment dated January 2, 2023, stating coumadin discontinued on November 16, 2022. Neither follow up assessment was completed on any of the uniform assessment tool requirements. On March 27, 2023, at 12:15 p.m., RN/licensed assisted living director (RN/LALD)-A stated R1 did not have any other assessments documented than the one provided with all three dates. RN/LALD-A stated she only reviews the assessment and documents no changes or the change that happened but does not use the uniform assessment tools required sections as she thought it was not needed. RN/LALD-A stated this is how assessments have been done on all six residents in this facility but moving forward will make use of the required uniform assessment tool. The licensee's Uniform Assessment Tool policy dated October 02, 2021, stated the licensee will use the uniform assessment tool that addresses	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 20 all the required elements to include: resident personal lifestyle preferences, activities of daily living, instrumental activities of daily living, physical health, emotional and mental health conditions, cognition, communication and sensory capabilities, pain, skin conditions, nutritional and hydration status and preferences, list of treatments and frequency, nursing needs, including delegation of tasks, risk indicators, decision making authority and the need for follow up referrals as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that prior to delegating medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 21 the proper methods to perform the task or procedure for each resident and the ULPs were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D started to work with the licensee on November 17, 2022. ULP-D's employee record contained competencies on the following topics dated November 17, 2022: - nasal sprays, - nebulizers, - liquid medications, - meter dose inhaler, - narcotics administration, - eye drops and ointments, - ear drops, - gastrostomy (G) tube medications, - injections, and - subcutaneous. All competencies were signed by both RN/LALD-A and ULP-D but each individual pass/fail area was blank (indicating ULP-D was not deemed competent). In addition, ULP's record included a partially completed competency for oral medications.	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 22 R3's Medication Administration Record (MAR) for February 2023, indicated ULP-D administered medications to R3 on various dates in the month of February. On March 28, 2023, at 9:00 a.m., RN/licensed assisted living director (LALD)-A stated the process for ULP medication training included one on one medication training taught by a RN, shadowing another medication passer, and ended with a competency skills review with the RN before providing medication administration to residents. In addition, RN/LALD-A stated ULP-D's competencies were supposed to indicate which areas were completed but licensee had not done so. RN/LALD-A indicated the competency review should have been completed for ULP-D but she did not know how to properly fill them out. The licensee's Medication & Treatment policy dated August 1, 2021, indicated ordered or prescribed medications and or treatment/therapy may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medication or perform the treatment or therapy, or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse at licensee. In addition, the policy indicated ULPs must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 29, 2023, the immediacy of correction order 1750 has been removed as confirmed by	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 23 supervisory review, however non-compliance remains at a scope and level of G.	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the documentation of medication administration included the signature and title of the person who administered the medication for two of two residents (R1, R3) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 24 The findings include: R1 was admitted September 20, 2022. R1's Daily Service Plan dated September 19, 2022, indicated R1 was receiving the following services not all included: medication administration, bathing assistance, laundry, mental health, and treatments as prescribed. R1's Medication Administration Record (MAR) dated March 2023, indicated R1 was taking the following medications: senna 8.6 milligram (mg) tablet give one tablet by mouth in morning and two tablets in evening, tizanidine 2 mg tablet take one tablet by mouth three times for thirty days, Symbicort 160 microgram (mcg) 4.5 mcg inhale 2 puffs by mouth twice daily, check blood sugar daily before breakfast, lidocaine ointment apply topically to neck and affected areas three times daily, apixaban 5 mg tablet take one tablet by mouth twice daily, and amlodipine 2.5 mg tablet take one tablet by mouth once daily. R3 was admitted September 20, 2022. R3's Daily Service Plan dated September 19, 2022, indicated R3 was receiving the following services not all included: medication administration, feeding, bathing assistance, grooming laundry, dressing, assistance with mobility and treatments as prescribed. R3's MAR dated February 2023, indicated R1 was taking the following medications: olanzapine 5 mg tablet by mouth give twice a day, omega 3 fish oil 1000 mg twice daily by mouth, omeprazole 20 mg capsule take one capsule by mouth before meals, topiramate 100 mg tablet take one tablet by mouth at night time, amitriptyline 100 mg tablet take one tablet at bedtime, carbamazepine 200 mg tablet take two by mouth twice daily,	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 25 diazepam 5 mg tablet take one tablet by mouth twice daily, duloxetine 60 mg capsule take one capsule by mouth twice daily, fenofibrate 160 mg tablet take one tablet by mouth daily with meals, and lithium carbonate 300 mg tablet take one tablet by mouth every night. R1 and R3's MARs included daily initialed boxes for each medication administered; however, the MARs did not include the signature and title of the person who administered the medication. On March 28, 2023, at 9:20 a.m., unlicensed personnel (ULP)-B stated the licensee trained staff to sign by their initials and the licensee's staff all know one another's initials. On March 28, 2023, at 9:50 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee should have included a signature page with titles for all employees who administer medications. The licensee's Medication and Treatment - Administration Delegation policy dated August 1, 2021, indicated "A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 26 days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications according to the manufacturer's directions for one of one resident (R1) only allowing authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: At 10:00 a.m. on March 27, 2023, during the entrance conference, the surveyor asked if the licensee had a medication refrigerator. Registered nurse/licensed assisted living director (RN/LALD)-A stated the licensee did not have any medications that needed to be stored in the refrigerator. R1's service plan dated August 20, 2022, indicated R1 received services of medication	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 27 management, self-blood glucose monitoring, and weekly injection administration. R1's Medication Management plan dated August 20, 2022, indicated R1 was unable to store prescribed medications independently and safely. R1's plan indicated R1 had special manufacturer's instructions (including refrigeration): insulin pens unopened in medication refrigerator. On March 28, 2023, at 8:00 a.m., the surveyor observed R1's medication administration record (MAR) dated March 2023, that included: Trulicity single dose pen. Surveyor asked to see the unopened pen, and unlicensed personnel (ULP)-B pulled R1's medication out from the unlocked resident food refrigerator in the kitchen and presented it to the surveyor. On March 28, 2023, at 8:20 a.m., RN/LALD-A stated she was unaware the Trulicity medication for R1 was being stored in the residents' food refrigerator, but she was aware the facility did not have a medication refrigerator. RN/LALD-A stated she was going out to purchase a medication refrigerator today and install it by this evening. The manufacturer's instructions for Trulicity single dose pen dated November 2022, indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit), but do not freeze it. If needed, each single dose pen can be kept at room temperature, not to exceed 86 degrees Fahrenheit for a total of 14 days. The licensee's Medication Storage policy dated August 1, 2021, indicated when medications are stored by [licensee], medications will be kept securely locked and stored per manufacturer's	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 28 directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880			
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required competency test. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02140			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2023
NAME OF PROVIDER OR SUPPLIER LEGACY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5230 CIRCLE DOWN GOLDEN VALLEY, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02140	Continued From page 29 The findings include: During the entrance conference on March 27, 2023, at 9:45 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she was responsible to provide direct resident cares and supervision of unlicensed staff, including training. RN/LALD-A was hired August 11, 2022. RN/LALD-A's background prior to assisted living was working as a RN in emergency room care and in a nursing home. On March 27, 2023, at 1:35 p.m., RN/LALD-A stated she was responsible for dementia care training of new employees; however, RN/LALD-A had not successfully completed a skills competency or knowledge test required by the commissioner for a qualified dementia trainer. The licensee's Dementia Training policy dated August 1, 2021, indicated a qualified trainer or supervisor must be available for consultation with new employees until training is complete. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		

Type: Full
Date: 03/28/23
Time: 09:47:56
Report: 1036231059

Food and Beverage Establishment Inspection Report

Page 1

Location:

Legacy Care Home
5230 Circle Down
Golden Valley, MN55416
Hennepin County, 27

Establishment Info:

ID #: 0041113
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. MDH PROVIDED AND EXPLAINED AN ILLNESS LOG DURING INSPECTION.

Comply By: 03/27/23

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1)

**** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW ANIMAL FOODS SUCH AS SHELL EGGS STORED OVER READY TO EAT FOODS IN REFRIGERATOR. ISSUE CORRECTED ON SITE.

Comply By: 03/27/23

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OBSERVED OPENED PACKAGES OF LUNCH MEAT IN THE FRIDGE WITH NO DATE LABEL. DEVELOP A CONSISTENT MARKING SYSTEM AND STICK TO IT.

Type: Full
Date: 03/28/23
Time: 09:47:56
Report: 1036231059
Legacy Care Home

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 03/28/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO CHLORINE TEST STRIPS ON SITE FOR MEASURING CONCENTRATION OF CHLORINE
SANITIZING BUCKET FOR HANDWASHED ITEMS. PROVIDE AND MAINTAIN A TEST KIT.

Comply By: 03/28/23

Surface and Equipment Sanitizers

Hot Water: = at >160 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 39 Degrees Fahrenheit - Location: KITCHEN FRIDGE

Violation Issued: No

Process/Item: Cold Hold/LUNCH MEAT

Temperature: 38 Degrees Fahrenheit - Location: KITCHEN FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 4 Degrees Fahrenheit - Location: KITCHEN FREEZER

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 6 Degrees Fahrenheit - Location: BASEMENT FREEZER

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	2	0

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS BENARD NYANGENA. INSPECTION CONDUCTED IN PRESENCE OF JESSICA ALLISON, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER

Type: Full
Date: 03/28/23
Time: 09:47:56
Report: 1036231059
Legacy Care Home

Food and Beverage Establishment Inspection Report

Page 3

- PEST MANAGEMENT

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

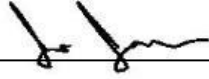
I acknowledge receipt of the inspection report number 1036231059 of 03/28/23.

Certified Food Protection Manager Jessica L. Allison

Certification Number: FM113104 Expires: 09/29/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jessica Allison
Food Manager

Signed:  _____
Jeff Johanson